BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

STEVE KOLAR, Claimant, v. JUB ENGINEERS, Employer, and AMERICAN MANUFACTURERS INSURANCE COMPANY, Surety, Defendants.	**IC 01-013706** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** Filed April 11, 2005

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Industrial Commission assigned the above-entitled matter to Referee Michael E. Powers, who conducted a hearing in Twin Falls, Idaho, on June 20, 2003. Claimant was present and represented by Harry DeHaan of Twin Falls. Eric S. Bailey of Boise represented Employer/Surety. Oral and documentary evidence was presented and the record was left open for the taking of post-hearing depositions. The parties submitted post-hearing briefs and this matter came under advisement on February 16, 2005.

ISSUES

The issues to be decided as the result of the hearing are:

1. Whether and to what extent Claimant is entitled to reasonable and necessary future medical care;

2. Whether Claimant is medically stable;

3. Whether and to what extent Claimant is entitled to permanent partial impairment (PPI) benefits;

4. Whether and to what extent Claimant is entitled to permanent partial or permanent total disability (PPD/PTD) benefits; and,

5. Whether and to what extent Claimant is entitled to benefits pursuant to Idaho Code § 72-451 for psychological injuries.

The issue of Claimant's medical stability was not argued in the parties' briefs and is deemed withdrawn.

CONTENTIONS OF THE PARTIES

Claimant contends that as a result of an accident wherein he was run over by a dump-truck, he sustained, *inter alia*, a severe degloving injury to his left thigh that has adversely affected his employability, and that he is entitled to further medical care and a substantial disability above impairment, if not odd-lot status, due to the reduction in his ability to engage in gainful activity.

Defendants concede that Claimant suffered a serious injury but deny that he has suffered psychological injuries to the extent that he contends. They point out that Claimant has worked at a job similar to his time-of-injury job at a higher rate of pay for almost two years post-accident without significant problems and is entitled to no PPD above impairment. Further, no physician has imposed any significant physical and/or psychological restrictions on Claimant's activities.

Claimant counters that the extent of his physical and psychological injuries has been underestimated. His current employer accommodates his fatigue and irritability that was not present pre-accident. Further, while Claimant is able to perform his current job with accommodations by a sympathetic employer, he would not be competitive in the labor market in

the event he lost that job. Finally, Claimant is entitled to additional PPI for his orthopedic and psychological injuries.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant, his spouse, and Employer's senior project manager presented at the hearing.

2. Claimant's Exhibits 1-5 admitted at the hearing.

3. Defendants' Exhibits 1-14 admitted at the hearing.

4. The AMA *Guides to the Evaluation of Permanent Impairment*, Fourth and Fifth Editions, (AMA *Guides*) of which the Referee takes notice.

5. The post-hearing depositions of: James Michael Retmier, M.D., taken by Claimant on July 21, 2003; Gerald Moress, M.D., with one exhibit taken by Defendants on July 23, 2003; David E. Nilsson, Ph.D., ABPP-CN, with two exhibits taken by Claimant on July 25, 2003; Jason L. Spooner taken by Claimant on August 18, 2003; Clinton Mallari, M.D., taken by Defendants on April 28, 2004; Craig W. Beaver, Ph.D., taken by Defendants on April 28, 2004; Douglas M. Crum, CDMS, with 4 exhibits taken by Defendants on May 13, 2004; Richard W. Worst, M.D., taken by Claimant on September 9, 2004; and Scott Lee Bybee taken by Claimant on September 9, 2004.

Claimant's objection at p. 8 of Dr. Moress' Deposition is sustained; Defendants' objection at p. 29 is overruled. Defendants' objection at p. 30 of Dr. Nilsson's Deposition is sustained. Defendants' objection at p. 10 of Mr. Spooner's Deposition is sustained; their objections at pp. 12 and 55 are overruled. Claimant's objection at p. 23 of Mr. Crum's Deposition is overruled; Defendants' objections at pp. 42 and 55 are sustained, their objection at p. 48 is overruled. Defendants' objection at p. 19 of Dr. Worst's Deposition is sustained.

Defendants' objection at p. 14 of Mr. Bybee's Deposition is sustained; their objection at p. 44 is overruled.

After having considered all the above evidence and the briefs of the parties, the Referee submits the following findings of fact and conclusions of law for review by the Commission.

FINDINGS OF FACT

1. Claimant was 46 years of age at the time of the hearing and resided in Twin Falls. His relevant work history has been in the field of engineering technician.

2. On June 8, 2001, Claimant was working as an engineering technician for Employer supervising the rotomill operation on a road-resurfacing project at Howell Canyon south of Burley. As Claimant was walking in the barrow pit on the side of the road, he was backed over by a Burley Highway District dump truck. Claimant remembers little of the accident but testified at hearing:

> Q. (By Mr. DeHaan): Were you knocked out?
>
> A. I don't know.
>
> Q. What parts of you were injured?
>
> A. I had a bump on my face.
>
> Q. Whereabouts?
>
> A. Right through here. I had a bruise or something on my lip. I have scars on my arm, my shoulder, my rib cage, my left leg, and on my knees. I also had bruising all over.

Hearing Transcript, p. 28.

3. Claimant was transported by ambulance to Cassia Memorial Hospital (CMH) in Burley where he presented with chief complaints of abrasions and contusions. The attending physician noted, "He is not sure whether he was unconscious, but he seems to remember the accident well enough that I doubt seriously if he was unconscious." Defendants' Exhibit 9. Claimant was noted to be oriented to time, place, and person and his recent and remote memory

appeared to be intact. Claimant had large abrasions over his left arm, left hip area, a smaller one over his left knee, and a significant abrasion over his left flank. X-rays of Claimant's pelvis, left hip, right knee, and left ankle were normal. Claimant's wounds were dressed and he was given Vicodin for pain and sent home with his wife.

4. Once Claimant arrived at his home in Twin Falls, he was unable to get from his vehicle to his house due to pain. Finally, he grabbed onto tables and chairs that were moved for him by his wife and his elderly father to get into his house.

5. The following day, Claimant was transported by ambulance to Magic Valley Regional Medical Center (MVRMC) after being informed by staff at CMH that there may be a problem with his SI joint based on new findings on his x-rays. He was given 2 mg of morphine for pain control en route. A pelvic CT scan at MVRMC was negative for fracture or other bony abnormality. Claimant was returned home by ambulance the same day and no abrasions to Claimant's head or face were noted in the paramedic's report. His Glasgow Coma Scale was 15. Defendants' Exhibit 3.

6. In the following months, Claimant had a JP pump installed to drain fluids from the large wound in his left thigh and he underwent two surgeries to drain a chronic seroma that had developed in that area. A home health care agency went to Claimant's home to care for his thigh wound and assist in draining the JP pump.

7. On April 29, 2002, Claimant saw Gerald R. Moress, M.D., a neurologist, at Surety's request for an evaluation. Upon his review of medical records and his physical examination, Dr. Moress reached a diagnosis of:

1. Status post soft tissue trauma left thigh.
2. Status post drainage large seroma left thigh.
3. Status post skin grafting left thigh.
4. Femoral sensory neuropathy left thigh.

5. Left hip abduction weakness.

Dr. Moress rated Claimant at 11% whole person PPI for left thigh femoral nerve sensory deficit and left hip abduction weakness without apportionment. He gave no rating for a skin graft over or cosmetic disfigurement of the left thigh.

8. Claimant saw James M. Retmier, M.D., a board certified orthopedic surgeon, at his attorney's request for a "disability evaluation." Upon his review of the medical records and his physical examination, Dr. Retmier concluded that Claimant had suffered a severe permanent degloving injury to his left thigh. He described a degloving injury in his deposition as follows:

> Q. (By Mr. DeHaan): Just what is a degloving injury, Doctor?
>
> A. A degloving injury, as the word might imply, was usually used when talking about injuries to the hand, wherein the most graphic and typical example is when someone has a ring on their ring finger, and it is caught on something , and then with a violent pull literally pulls the entire skin and subcutaneous tissue off the finger leaving the skeleton behind. And that is the classic description of a degloving injury as it applies to a finger.
>
> We use that term, though, to describe similar injuries to other areas of the body, usually the extremities, wherein basically a thick layer of soft tissue, like skin and fat or muscle, is pulled by traction away from the underlying tissues. So it's not a clean cut, it's a pulling or a traction type of injury.

Dr. Retmier Deposition, pp. 7-8.

9. Dr. Retmier testified that he believed Claimant's pain complaints were consistent with his physical findings and that Claimant minimized those complaints. In utilizing the AMA *Guides*, Fourth Edition, Dr. Retmier assigned a 15% whole person PPI on the "conservative" end up to 25% depending on the extent of Claimant's debilitation due to chronic pain.

10. On June 7, 2002,[1] Claimant saw Clinton Millari, M.D., a board certified physical and rehabilitation physician, as a referral for an impairment rating from Dell Smith, M.D., a

[1] Dr. Mallari's office note for his one and only visit with Claimant is dated June 7, 2002; however, Dr. Mallari testified in his deposition that he saw Claimant in August of 2002. *See*, Defendant's Exhibit 5 and Dr. Mallari Deposition, pp. 6 and 7.

cosmetic surgeon who had been treating the large seroma on Claimant's left thigh. Dr. Millari reviewed Dr. Smith's records and performed a physical examination. Dr. Mallari found:

> " . . . no physical or cognitive deficits in this individual. The only finding that I could assess was some numbness in his left anterior thigh. Which was a sensory loss, not a motor loss. No weakness in that leg. And it did not affect his movement or gait."

Dr. Millari Deposition, p. 8.

11. Dr. Millari characterized his examination as "normal" and he found no physical restrictions. He assigned a 1% whole person PPI rating for a sensory deficit at the L2-L3 dermatome pattern based on the AMA *Guides*, Fourth Edition. He found no evidence of a closed head injury.

12. On November 20, 2002, Claimant saw David E. Nilsson, Ph.D., a clinical neuropsychologist practicing in Salt Lake City, at his attorney's request to assess any potential neurocognitive and/or neurobehavioral sequelae of his injuries. Claimant's wife testified that right after the accident, Claimant started having trouble sleeping then developed problems with emotional lability and anger as well as becoming easily fatigued and withdrawing from family and friends. It was reported to Dr. Nilsson that Claimant was experiencing personality changes, short-term memory loss, and some dizziness. Dr. Nilsson and his staff administered a variety of neuropsychological testing. Claimant and his wife met with Dr. Nilsson on March 15, 2003, to discuss Dr. Nilsson's findings and recommendations.

13. Claimant initially informed Dr. Nilsson that he may have lost consciousness at the time of his accident but it "didn't seem like very long." Exhibit 2 to Dr. Nilsson's Deposition. Claimant was administered a battery of tests that Dr. Nilsson determined to be valid. Claimant's scores ranged from a low of 16 percentile to a high of 99 percentile. Dr. Nilsson concluded that

Claimant's accident exacerbated his pre-existing anxiety. In his deposition, Dr. Nilsson explained the effects of even a relatively mild concussive episode this way:

> Q. (By Mr. DeHaan): Doctor, what did you see that gave you a history of a concussive incident?
>
> A. The first characteristic was that of a rather impressive change in his – his ability to manage stress, becoming very easily frustrated. His – he had gone from where he had had had [*sic*] some anxiety to where he was becoming immobilized by his anxiety.
>
> Q. Over what period of time?
>
> A. Well, as is the case for a lot of patients I follow with such an injury, in the early stages as they're recovering from the physical aspects of the injury, they're less aware of and verbalize much less about a lot of the more cognitive or emotional/behavioral kinds of consequences.
>
> In this case, that seemed to be the case, and his report and awareness of those seemed to evolve. As I remember, it was roughly six months or so after, but often they're there but the patient is just not aware of them because of the recovery and the other physical symptoms.
>
> He had a lot of complications with his leg and required a lot of medical attention that would distract from the process.

Dr. Nilsson Deposition, p. 10.

14. On July 12, 2003, Claimant saw Craig Beaver, Ph.D., a clinical neuropsychologist practicing in Boise, one time only at Defendants' request to address Dr. Nilsson's diagnosis of a closed head injury. Like Dr. Nilsson, Dr. Beaver also administered a battery of tests to Claimant. After reviewing the results of the tests, interviewing Claimant, and reviewing his medical records, Dr. Beaver agrees Claimant may have suffered a relatively minor concussion, but he does not believe that is what is causing Claimant's current "difficulties" or that he has any residuals of a traumatic brain injury (TBI). While somewhat lengthy, the following testimony from Dr. Beaver provides a detailed insight into the complexity of diagnosing Claimant's psychological state:

> Q. (By Mr. Bowen): And why do you believe that [no residuals from a mild concussion] to be the case?

A. A couple of things. First of all, in talking with Mr. Kolar, and looking at the record around the time of the accident, he both does not describe, nor does anyone else who initially treated him, any loss of consciousness from the accident. Which is not a necessary ingredient to have a head injury. You can still have a head injury without that. But also in reviewing what happened to him, he actually has pretty good recall of the accident. But only, at most, a momentary period of time from when he got hit to when people were running to help him that he says he doesn't remember things. So he doesn't show any extended period of post-traumatic amnesia, as best as I can tell.

So those right there would indicate that certainly getting hit by a truck – although there is [*sic*] some differences also in how he described getting struck by the truck versus Dr. Nielson [*sic*] – you know, you can have a concussion from that. But given the fact that he didn't have any loss of consciousness, didn't have any significant period of post-traumatic amnesia, just in terms of the outset, you wouldn't expect it to be something severe. You would probably expect it to be relatively minor.

Then if you go through his medical records and his history clearly the main concern and focus for Mr. Kolar was his leg injury. And so in that regard it is not surprising that that was the primary thing that is talked about in the medical records throughout. But with some of the people that had been seeing him routinely, at least from some of the medical records, there is no discussion about him having significant difficulties with his thinking skills and abilities.

Now, when he sees Dr. Neilson [*sic*], which is then about - - actually, that is quite a bit later. It is over a year post he talks about problems. And, in fact, he talked about some cognitive problems with me. But Mr. Kolar was, I thought, pretty straightforward. He felt that he really did not notice or become aware of those neurocognitive problems until March of 2002. Now, this was around the time that he was getting towards the end of the more aggressive treatment that he was having to undergo for the leg. But, nevertheless, that is when those concerns really came up.

And so all of that, in terms of history, is not very suggestive of somebody who had a significant brain injury, showed some gradual recovery over time, and then has some residual problems down the road. To me it was more suggestive of somebody who had a horrible injury. And I think, you know, had a lot of difficulty post-accident with medical care and treatment that he had. I mean, I think it was a pretty lousy life experience. And I think he got really depressed and emotionally distressed. And my opinion is that that is the primary cause of his cognitive difficulties. And that would fit with the time line he talks about.

Then Mr. Kolar was tested - - he was first tested by Dr. Nielson [*sic*]. And then tested by me. He actually did pretty well in the testing. Both when Dr. Nielson [*sic*] tested him and when I tested him. He didn't show a consistent pattern of cognitive deficits. Particularly in higher-level cognitive activities, which is the common pattern you see following a mild traumatic brain injury.

He did, however, show a lot of emotional duress during the time that I saw him. And from what I can tell in Dr. Nielson's [*sic*] report, that was also present. And that would make sense. And to me the kinds of things that he talks about

having difficulty with I believe are a reflection of that emotional distress, rather than a reflection of residual traumatic brain injury.

Dr. Beaver Deposition, pp. 12-15

15. Dr. Beaver likened Claimant's "significant emotional distress" to some elements of post-traumatic stress syndrome (PTSD) that has resulted in anxiety and depression. Dr. Beaver referred Claimant for further treatment to Richard W. Worst, M.D., a psychiatrist practicing in Twin Falls.

16. Claimant first saw Dr. Worst on November 20, 2003,and had seen him five times up to the date of Dr. Worst's deposition on September 9, 2004. Upon examination and review of records, Dr. Worst arrived at the diagnosis of a possible TBI and probable PTSD causing depression, anxiety, fatigue, and avoidance. He agrees with Dr. Nilsson that Claimant probably suffered a TBI at the time of the accident and that Claimant received "essentially" a concussion. Regarding Dr. Beaver's opinions, Dr. Worst testified:

Q. (By Mr. DeHaan): And do the – do you agree or disagree with Dr. Beaver's findings of essentially depression?

A. Well, I do, except I put it under the heading of posttraumatic stress disorder, where depression can be a prominent symptom. So we agree on the fact that the man has depression. We may have disagreed at that point on whether the depression was a major depression versus the type of depression you see with posttraumatic stress disorder. Although it's my impression, from talking to Dr. Beaver over the phone later, that he was in agreement that the man had a posttraumatic stress disorder. I could be wrong on that, but that's the impression I have right now.

Q. And do you think that the posttraumatic distress disorder is caused by this industrial accident?

A. Yes, I do.

Dr. Worst Deposition, pp. 6-7.

17. Dr. Worst, in his deposition, sheds some light on the difficulty in reaching a definitive diagnosis in this case:

Q. (By Mr. DeHaan): Doctor, you referred several times to the subtleties of diagnosing this case. Can you explain that. [*sic*]

A. Well, I can certainly try. In the field of psychiatry, it's by nature not as subjective as orthopedics, where you have an X-ray, you see a broken bone, you don't see a broken bone, you nail it up. You take another X-ray, you see if the nail's in the right place. I envy that type of thing, you know. In psychiatry, it's much more subtle. And things overlap. And they overlap with normalcy. I mean, in a normal work situation, there's some stress, workers get frustrated, they get angry, they take it out on their wife.

Q. Or vice versa?

A. Or vice versa, that's normal. But when you get into psychiatry, you've got a person that – he did, in my opinion, have a legitimate concussion. Now, there is a concussion syndrome. We're all pretty much in agreement that's probably resolved, but there's really no way we can prove that, but probably it has. But that can cause anxiety, depression, irritability, problem in memory, focus, all those things, exactly the same things that posttraumatic stress disorder can cause.

Now, the reason that I'm more focused on the posttraumatic stress disorder is because the trauma there was so obvious, where he did have this really panicking, terrifying, life-threatening experience in which he consciously experienced himself bleeding to death.[2] Now that's – that's significant. And his symptoms, the medical avoidance, all fit with that.

So again, the point is that it's – there's overlap, there's the issue of normalcy, so – and then in this particular case, because this man is a worker and he tries hard and he works long hours, if you just look at that, you could take the position, well, this guy's fine, he's completely recovered, which is not true at all.

Dr. Worst Deposition, pp. 15-16.

DISCUSSION AND FURTHER FINDINGS

Future medical care:

Idaho Code § 72-432 obligates an employer to provide appropriate medical care immediately following an industrial accident and for a reasonable time thereafter.

18. Defendants do not dispute and the Referee finds that the ten "discretionary sessions" recommended by Dr. Worst in the event Claimant has " . . . some crashes in the next

[2] Dr. Worst is apparently referring to an incident wherein the JC pump that had been attached to Claimant's left thigh to drain fluids collecting there had somehow malfunctioned and began pumping Claimant's blood out or causing a leakage and he nearly bled to death. An operative report dated September 2, 2001, refers to a probable hemorrhage to Claimant's left anterior thigh for which claimant was hospitalized and operated on by Dr. Smith. Claimant's wife testified that Claimant's aversion/avoidance of medical treatment intensified after this episode.

three years" is reasonable and Defendants are liable therefor in the event Claimant avails himself of Dr. Worst's offer.

PPI – Orthopedic:

"Permanent impairment" is any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved and which abnormality or loss, medically, is considered stable or nonprogressive at the time of the evaluation. Idaho Code § 72-422. "Evaluation (rating) of permanent impairment" is a medical appraisal of the nature and extent of the injury or disease as it affects an injured worker's personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, elevation, traveling, and nonspecialized activities of bodily members. Idaho Code § 72-424. When determining impairment, the opinions of physicians are advisory only. The Commission is the ultimate evaluator of impairment. *Urry v. Walker Fox Masonry Contractors*, 115 Idaho 750, 755, 769 P.2d 1122, 1127 (1989).

19. There is no agreement among the physicians who have rated Claimant concerning the level of PPI for his orthopedic injuries. Dr. Moress assigned an 11% whole person PPI. When asked to explain the difference between his 11% and Dr. Retmier's 15%, Dr. Moress testified:

> Q. (By Mr. Bailey): Can you tell me what differences, if any, there are between your two reports that you think are important for us to know about?
>
> A. Well, there may not be any significant difference. I think the small percentage differential between them may be because Dr. Retmier added a percentage for pain which I always include it as part of the impairment rating, but I have no objection to that. And the fifteen and the eleven are not that far apart.

Dr. Moress Deposition, p. 9.

20. Dr. Mallari assigned a 1% whole person PPI. Dr. Moress disagrees with that rating because Dr. Moress found weakness in Claimant's hip where Dr. Mallari found that Claimant's motor examination was normal.

21. Defendants concede in their brief that " . . . Claimant should probably get the additional 4% rating for pain as opined by Dr. Retmier in his report." Defendants' Post-Hearing Brief, p. 21. The Referee finds that Claimant has suffered a 15% whole person PPI as the result of his industrial accident and injury.

PPI – Psychological injury:

22. Defendants agree that Claimant has suffered some psychological impairment as the result of his industrial accident and injury but argue that the impairment should be the 5% whole person rating assigned by Dr. Beaver for PTSD but not for a TBI that Defendants deny Claimant suffered. They argue that Dr. Beaver's testimony and opinions should carry more weight than Dr. Worst's primarily because Dr. Worst's opinions are not supported by the medical records. In particular, they question Claimant's account of almost bleeding to death as unsupportable in the records. However, as pointed out in footnote number 2, there is a record of a probable hemorrhage to Claimant's left thigh on September 2, 2001. Claimant's wife testified that, "And just before Labor Day when [Claimant] was in the hospital for Labor Day when he nearly bled to death – and he dramatically got worse after that about medical treatment, so he -- " Hearing Transcript, p. 62. The Referee takes notice that Labor Day fell on September 3 in 2001. While that portion of the record may have been more thoroughly developed, nonetheless, a medical record does exist that corroborates Dr. Worst's testimony regarding the foundation for his PTSD diagnosis.

23. Dr. Beaver testified as follows regarding his assignment of a PPI rating for Claimant's psychological condition:

Q. (By Mr. Bowen): Do you have an opinion within a reasonable degree of probability whether Mr. Kolar has suffered some permanent impairment as a result of the psychological difficulties he has experienced post accident and injury?

A. Yes.

Q. What is your opinion, sir?

A. I think that based upon current information that he would warrant an impairment.

Q. Of what?

A. I would say five percent under the guidelines. I mean, he is independent, living independently, being able to work. But it does cause him some difficulties in what he does. Unfortunately, the AMA Guidelines, Fifth Edition, which is what we usually utilize as a guide is not very clear. But I would put him in the Class II range, broadly. You know, there is [*sic*] some things that may be worse at times and some things that are obviously better at times. But I think if you had to categorize him, Class I means, no, that you have a psychological difficulty that caused no problems for you. Class II indicates that you have a psychological problem. You are still able to function adequately. And I think that would probably be an apt description for Mr. Kolar.

Dr. Beaver Deposition, pp. 32-33.

Dr. Beaver did not apportion any of his 5% whole person PPI to Claimant's pre-existing anxiety.

24. Dr. Nilsson testified as follows regarding his opinion of Claimant's PPI for his psychological condition:

Q. (By Mr. DeHaan): You're familiar with the Guides to Evaluation of Permanent Impairment, Doctor?

A. Yes.

Q. Fifth Edition?

A. Yes.

Q. And they talk about classes of impairment due to mental and behavioral disorders. They rank them in five categories, from no impairment, mild, moderate, marked, and extreme.

Are you familiar with those classifications?

A. Yes.

Q. In which classification would you put this patient?

A. Well. Probably across those five, those five levels, depending on the specific level, he would range from probably from 2 to 4.[3]

I haven't recently gone through for him specifically, so I don't recall in each of the areas; but the thing that makes him a little more difficult, is that depending on his level of pain, that that will vary more dramatically, and hopefully that that can be more effectively and productively controlled.

Dr. Nilsson Deposition, p. 31.

25. Dr. Worst testified as follows regarding his opinion of Claimant's PPI for his psychological injury:

Q. (By Mr. DeHaan): And do you have an opinion as to the degree of permanent disability [*sic* - - impairment] that Mr. Kolar has suffered?

A. Well, using the guidelines that I looked at the other day, he is functional up to a point. So I think that led to a moderate degree of impairment, if I remember correctly.

Q. And that would be class 3?

A. That's correct, yes.

Q. And there is some room for discretion in the percentages within Class 3, and what percentage of disability would you allocate to this patient?

A. Well. If I remember correctly, the percentage they offered was 25 to 50 percent.[4] And using those figures, I would put him on the low end of that, because, in fact, he is functioning pretty well right now in some –

Q. You told me 50 percent the other day.

A. Huh?

Q. You said 50 percent the other day.

A. Well, I don't know then if I was focused entirely on that or had it right in my head. I don't know that I would say he's at – I'm uncomfortable saying he's at the top end of that range. I would say perhaps it' more fair to say he's more in the middle, somewhere like that, from – so I guess if the middle would be 37.5 or something like that. So I think he would be closer to 30 to 37, realizing these numbers are – they're the best people can do, but they're very off, because again, I'm having to speculate into this [*sic*] life's events. But

[3] The Referee notes that the AMA *Guides*, Fifth Edition, does not include corresponding numerical ratings for each category or range of impairment.

[4] The Referee takes notice that the AMA *Guides*, Fourth Edition contains a comment on why that edition also declined to use percentages for estimates of mental impairment. Within that comment are references to impairment ranges included in the AMA *Guides*, Second Edition. The range of impairment within Class 3 for moderate impairment is 25%-50%. The reason given for not including percentages in the Third and Fourth editions was that the procedure utilized in the Second edition was highly subjective and unlike the situation with some organ systems, there are no precise measures of impairment in mental disorders and the use of percentages implies a certainty that does not exist. *See*, the AMA *Guides*, Fourth Edition, p. 301.

nevertheless, even not focused on life's events, just taking where he's at right now, in my opinion, he's got a moderate degree of impairment here, and probably somewhere, 30, 35 percent seems fair to me.

Q. Okay. And are you aware that Dr. Beaver had him much lower?

A. I have heard that.

Q. And do you have any rationalization for that?

A. Well, possibly the fact that Dr. Beaver isn't as up-to-date with him as I am, possibly hasn't focused on the psychosocial issues as much, and also hasn't had the treatment failure experience, because I started out to treat him with two or three different medications, and ran into failure. And so, therefore, that's going to color my view, and I'm going to see this man's situation as probably more severe than Dr. Beaver is.

. . .

Q. (By Mr. Bowen): Now, with respect to your discussion of impairment, I gather what – it was a little all over the board. You believe the gentleman is in the middle of Class 3, at the lower end of Class 3, what do you think?

A. I would say from somewhere from the middle down. I mean it's such a vague term, that, you know, it's very hard to get a hold of. If I'm forced to throw something out, the lowest level in Category 3 is 25 percent, the highest level is 50 percent. I don't think he would be near the 50 percent range, I think he would be somewhere between 25 and, say, 37 ½.

. . .

Q. Do the guides give us any guides as it were, as to what constitutes moderate impairment?

A. Well, they do a little bit. I'm standing up right now to see if I can – they give you some discussion, but I'm looking – it's chapter 14, mental and behavioral disorders, page 301. And under Class 3, all they're saying is impairment levels are compatible with some, but not all, useful function. And that's essentially the way I see him. He certainly does have some useful functioning, but he's – but not, by no means, is he back to normal or anything close to it.

Now, mild impairment is compatible with most useful functioning, and I would say that doesn't fit, in my opinion. He's not functioning – he's functioning okay at work because he's got a supervisor that cuts him a lot of slack and protects him from stress. I think, to a large degree, his wife would say things that aren't even close to being what they used to be. And she's kind of like the supervisor, you know, she's cutting him a lot of slack and protecting him. So to me, that would not be the case if his level was compatible with functioning with most useful functioning, you know, functioning most of the time. I don't think he's functioning – frankly, I think he's just barely making it most of the time.

And probably in all fairness, it could be argued that probably in pretty much no level of his life, none, is he back to anywhere close to where he was before this accident. He's getting the job done, but he isn't back to normal.

Dr. Worst Deposition, pp. 20-23; 38-39; and 41-42.

26. Dr. Worst's testimony underscores the challenges presented in attempting to assign an impairment rating for mental injuries or disorders. The AMA *Guides* provide little guidance in this area and no one in this case discussed whether ratings were provided for under any edition of the Diagnostic and Statistical Manual of Mental Disorders. While the variables are many, nonetheless, our system mandates that any impairment, whether physical or mental, be quantified as a numerical percentage of the whole person. In this case, the Referee is more persuaded by the opinion of Dr. Worst over those of Drs. Beaver and Nilsson regarding impairment. Dr. Worst provided a lengthy explanation of the difficulties and variables involved in the rating process and expressed more familiarity with Claimant's situation, as he has been involved in his treatment. While agreeing with the comment in the AMA *Guides*, Fourth Edition that providing a percentage implies a certainty that does not exist (*See,* footnote 4), the Referee finds that Claimant has suffered a 30% whole person PPI as the result of mental/psychological injuries sustained in his industrial accident. The Referee finds it unnecessary to engage in the debate over whether Claimant suffers from an organic brain injury, a "concussive" syndrome, PTSD, or some other condition as all the mental health practitioners agree that his fatigue, irritability, depression, emotional duress, cognitive difficulties, etc., stem from his accident. While a precise diagnosis might be helpful in treating Claimant, it is not necessary to assign a PPI rating for his symptoms, no matter how described.

PPD:

"Permanent disability" or "under a permanent disability" results when the actual or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental or marked change in the future can be reasonably expected. Idaho Code § 72-423. "Evaluation (rating) of permanent disability" is an appraisal of the injured

employee's present and probable future ability to engage in gainful activity as it is affected by the medical factor of impairment and by pertinent non-medical factors provided in Idaho Code §72-430. Idaho Code § 72-425. Idaho Code § 72-430(1) provides that in determining percentages of permanent disabilities, account should be taken of the nature of the physical disablement, the disfigurement if of a kind likely to handicap the employee in procuring or holding employment, the cumulative effect of multiple injuries, the occupation of the employee, and his or her age at the time of the accident causing the injury, or manifestation of the occupational disease, consideration being given to the diminished ability of the affected employee to compete in an open labor market within a reasonable geographical area considering all the personal and economic circumstances of the employee, and other factors as the Commission may deem relevant, provided that when a scheduled or unscheduled income benefit is paid or payable for the permanent partial or total loss or loss of use of a member or organ of the body no additional benefit shall be payable for disfigurement.

The test for determining whether a claimant has suffered a permanent disability greater than permanent impairment is "whether the physical impairment, taken in conjunction with non-medical factors, has reduced the claimant's capacity for gainful employment." *Graybill v. Swift & Company*, 115 Idaho 293, 294, 766 P.2d 763, 764 (1988). In sum, the focus of a determination of permanent disability is on the claimant's ability to engage in gainful activity. *Sund v. Gambrel*, 127 Idaho 3, 7, 896 P.2d 329, 333 (1995).

27. Claimant's educational and work history is in the area of engineering. At the time of the hearing, Claimant was working full time for the City of Jerome as an engineering technician since April of 2002, basically the same job that he was performing at the time of his industrial accident. He was receiving benefits and was making $15.50 an hour; he made $13.30 an hour at the time of injury.

28. Claimant retained Douglas N. Crum (Crum) and Defendants retained Jason L. Spooner (Spooner) to assist them with vocational issues. Crum testified by way of deposition that because Claimant is now making more money per hour than he was pre-accident he has not suffered any wage loss. Based on a Functional Capacities Evaluation (FCE) that essentially placed Claimant in the medium work category, Crum opined that based on Claimant's education and experience, he has suffered no loss of access to his labor market. Crum's ultimate opinion is that Claimant has suffered no PPD in excess of whatever PPI the Commission may decide upon.

29. Spooner also testified by way of deposition. It is his opinion that because Claimant did not compete for the job he now holds,[5] he would not otherwise have been able to secure that employment because of his fatigue and inability to work a productive eight hour day. Spooner opines that Claimant has lost between 36 and 37.7 percent of his labor market if one eliminates heavy and medium duty jobs due to the fatigue factor.

30. Claimant testified that he becomes fatigued towards the end of the work day and is inclined to make errors in measurements and other tasks. His left leg bothers him in kneeling, bending, climbing ladders, jumping across objects like ditches, and walking across uneven ground. Claimant also testified it was necessary for him to take a nap during his lunch hour to keep from getting so fatigued by the end of the day.[6] Claimant used to enjoy golf, hunting, and fishing but no longer participates in those activities due to fatigue and lack of interest. Because of his fatigue and proclivity to make errors, he is afraid he might lose his job with the City of Jerome.

31. Bill Black testified at hearing regarding Claimant's work habits at his time-of-injury job. Mr. Black was the regional manager for Employer when Claimant was injured. He

[5] Claimant secured his present employment through a person that was his supervisor at his time-of-injury job who later became the City Engineer for Jerome; there was no 'formal" interview process or any other job candidates vying for the position.

[6] Claimant testified he only sleeps about two hours a night due to anxiety which leads the Referee to question how he is able to sleep during his lunch hour.

testified that Claimant was a loyal and well-liked employee but was reluctant to ask for help and made some mistakes. Mr. Black was present for Claimant's hearing testimony and testified that the examples of problems Claimant was having with his current job were similar to the problems he was having with Employer herein.

32. Scott Bybee, the Jerome City Engineer, is Claimant's current supervisor and was, from the summer of 1999 until June of 2000, his supervisor at Employer's. Mr. Bybee testified that in the time he worked with Claimant at Employer's, it was not uncommon for him to work 10-14 hour days. Mr. Bybee described Claimant's attitude and work product at Employer's as "above average." Mr. Bybee hired Claimant to help him with various projects in April of 2002 at the City of Jerome. Mr. Bybee noticed a level of fatigue and irritability in Claimant that he had not seen before and he would sometimes make errors in calculations later in the day. Mr. Bybee learned from an unnamed counselor of Claimant's some of the difficulties he was experiencing and has accommodated Claimant's fatigue/irritability issues to some extent.

33. An FCE on Claimant was accomplished on February 4, 2003, and placed him in the medium work category and concluded, "I would recommend that Steve frequently switch positions between sit/stand/walk, and be able to alter work activities to minimize deep squat, kneel, and repetitive squatting." Defendants' Exhibit 10.

34. There are minimal physician-imposed physical restrictions in this case. Claimant's initial treating physician, Dr. Smith, has released Claimant to return to work without restrictions on a number of occasions. Dr. Millari did not impose any restrictions. Dr. Moress initially indicated Claimant may have trouble getting up from a squatting position but accepted the results of the FCE at his deposition. Dr. Retmier also endorsed the FCE. Drs. Nilsson, Beaver, and Worst imposed no restrictions based on psychological factors.

35. Claimant argues that he is basically employed by a sympathetic employer and that in the event Mr. Bybee leaves his employment with the City of Jerome, or Claimant is fired or gets divorced, that he will incur significant PPD in excess of his PPI. The Referee cannot find

that the City of Jerome is a sympathetic employer. Mr. Bybee testified that he considers Claimant to be a valuable employee not working at a "make work" job who has no more chance of losing his job than any other city employee working under the city's budgetary restraints. How Claimant may react under certain hypothetical situations that may occur in the future is speculation. PPD is evaluated by accessing the effect of PPI and pertinent non-medical factors have on a claimant's actual and presumed and present and future ability to engage in gainful activity. The Referee cannot ignore the fact that Claimant has been gainfully employed by the City of Jerome performing the essential functions of his job since April 2002. There is no credible evidence that he will not remain so employed. He is earning more money now than he was at his time-of-injury job, has received raises and, in fact, Mr. Bybee testified at his September 9, 2004, deposition that he will be recommending Claimant for yet another raise. Claimant's actual and present ability to engage in gainful activity has not been affected by his PPI and pertinent non-medical factors as he continues to work for the City of Jerome at a higher wage with the opportunity for future wage increases. There is no credible evidence that Claimant's employment will end. Therefore, there is no reason to presume that Claimant's probable future ability to engage in gainful activity will be reduced by his PPI and pertinent non-medical factors.

36. The Referee finds that Claimant has failed to prove he is entitled to any PPD in excess of his PPI.

CONCLUSIONS OF LAW

1. Claimant is entitled to future medical care for "discretionary" sessions as recommended by Dr. Worst.

2. Claimant is entitled to a 15% whole person PPI rating for his orthopedic injuries and an additional 30% for his psychological injuries for a combined whole person rating of 41%. *See*, AMA *Guides*, Fifth Edition, Combined Values Chart, p. 604. Defendants are entitled to a credit for any PPI benefits previously paid.

3. Claimant is not entitled to PPD above his 41% whole person PPI.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Referee recommends that the Commission adopt such findings and conclusions as its own and issue an appropriate final order.

DATED this __28th __ day of __March___, 2005.

INDUSTRIAL COMMISSION

__/s/_____
Michael E. Powers, Referee

ATTEST:

__/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __11th __ day of __April__, 2005, a true and correct copy of the **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

HARRY DEHAAN
335 BLUE LAKES BLVD N
TWIN FALLS ID 83301-4828

ERIC S BAILEY
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ge ___/s/_____